MDR Tracking Number: M5-04-4002-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 7-22-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the Electrical Stimulation, Ultrasound, Therapeutic Processes, Therapeutic Activities, Office Visits, Consulatation X-Ray Exam, and Radiologic Exam from 7-23-03 through 12-2-03 were not medically necessary.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service 7-23-03 through 12-2-03 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 24th day of September, 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

DA/da

NOTICE OF INDEPENDENT REVIEW DECISION

Date: September 22, 2004

RE:
MDR Tracking #: M5-04-4002-01
IRO Certificate #: 5242

_____ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to _____ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

_____ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by an Orthopedic Surgeon reviewer (who is board certified in Orthopedic Surgery) who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed

the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- Medical documents of treatment by _____
- Medical documents of treatment by _____
- Medical documents of treatment by _____

Submitted by Respondent:

- Medical documents of treatment by _____
- Medical documents of treatment by _____
- Medical record review dated 11/14/03
- RME report dated 5/4/04

Clinical History

The claimant sustained injuries to the neck and right shoulder from an alleged work injury that occurred on or about ___. The mechanism of injury is variously described as a traction injury to the shoulder and neck while carrying a heavy load on the shoulder. An EMG/NCV study on 5/14/02 reportedly documents no radiculopathy, no brachial plexopathy and no significant neck or shoulder findings only compression syndrome of median nerve at both wrists. An MRI report of the right shoulder of 5/9/02 indicates mild tendinopathy of the rotator cuff with no evidence of rotator cuff tear or other pathology. MRI report of the cervical spine of 5/3/02 indicates mild degenerative disc disease consistent with the claimant's age and no documentation of nerve root compression. The claimant has undergone an arthroscopic surgery of the right shoulder on 1/9/02 and has recovered from the surgery. A psychological evaluation on 12/3/02 indicates the presence of non-physiologic symptoms with multiple positive "Waddell's signs".

Requested Service(s)

97032 – Electrical Stimulation, 97035 – Ultrasound, 97110 – Therapeutic Processes, 97530 – Therapeutic Activities, Office Visits, 76140-26 – Consultation X-Ray Exam, 72050 – Radiologic Exam for dates of service 7/23/03 to 12/2/03

Decision

I agree with the insurance carrier that the services in dispute were not medically necessary.

Rationale/Basis for Decision

The claimant underwent a thorough diagnostic work up including EMG/NCV studies, radiographs, and MRIs of the shoulder and neck. These studies have failed to show significant injury associated with the alleged compensable work event. Despite a lack of clear indications,

the claimant underwent a surgical procedure on 1/9/02. The claimant has recovered from the surgery. Generally supervised physical therapy is indicated in the presence of significant deficits in range of motion and functional capacity usually associated with acute injury or perioperative conditions. The physical therapy modalities including electrical stimulation, ultrasound, therapeutic processes, and therapeutic activities instituted from 7/23/03 through 12/2/03 were prescribed over 2 years following an alleged lifting injury and there is no clear explanation why a well structured home exercise program and conventional ice/heat modalities would be any less effective than continued active intervention in this clinical setting. There is no clear indication for the medical necessity of additional office visits, consultation or radiologic work up in light of a thorough clinical work up that has included multiple imaging studies and neurodiagnostic testing which have failed to reveal significant findings that would indicate the need for additional studies. The claimant has undergone an exhaustive clinical work up, and I strongly recommend that the claimant's future management focuses on vocational rehabilitation.